Making Space for Mental Health Care within the Penal Estate

Abstract

In this paper we explore the enfolding spatialities of control and care within the penal estate through analysis of the creation of a unit for prisoners with serious mental illnesses (SMIs). Prisons have increasingly become the key institutions for mental health care provision, yet serious mental illness disrupts the self-government upon which contemporary prison regimes are based. Our analysis highlights the 'trouble' institutions face in making space for mental health care; in trying to fit different control-care regimes into existing carceral environments. We argue that the different actors that have made space for this control-care have been open to potentiality. Developments have been experimental, emergent and incomplete; often not officially challenging wider institutional processes, but eluding them. What emerges is an institution within an institution with a certain level of spatial autonomy but constrained in its transformative potential.

Introduction

There has been concern for some time that the de-institutionalisation of mental health care has been accompanied by a re-institutionalisation of those with mental health care needs within prisons (Dear and Wolch, 1987; Nickerson, 1985). Mental illness and well-being are frequently negatively impacted by experiences of incarceration (Crewe, 2011). Prisoners with serious mental illnesses (SMIs) are 'troublesome' (Philo and Parr, 2019) to prisons as institutions at a time when they are also troubled by overcrowding within a penal estate that has been slow to adapt not only to shifts in punitive regimes but also to changing approaches to mental health care. Prisons have historically sought to move out those whose mental illnesses mean they are unable to self-govern (Crewe, 2011; Foucault, 1977) in a way required not only by contemporary penal regimes (Duke et al, 2018); this separation has been noted by both Foucault (1965) and Philo (2004) as being apparent in institutional formations since the 1700s. However, the growing numbers of prisoners with SMIs alongside austerity politics that has restricted or reduced capacity beyond prisons for secure care, are forcing contemporary prison authorities to (re)consider how they can accommodate care for serious mental illness within the penal estate (Dyer et al, forthcoming).

In this paper we explore these enfolding spatialities of care and control (McGeachan, 2019) in a large reception prison in the North of England as the mental health care provider and prison authorities 'make space' for prisoners with SMIs. In doing so, we contribute to critical debates in institutional geographies (Philo and Parr, 2019; Philo and Parr, 2000) concerning the 'trouble' institutions both present and to which they are subject in the contemporary context (Disney and Schliehe, 2019). In particular, we want to argue for 'staying with' (Philo and Parr, 2019) not just trouble in general, but a particular aspect of trouble that has faced institutions since the 1700s (Foucault, 1965; Philo, 2004), namely the intersection of mental illness and criminality and their dialogical relationship with institutional forms both material (or architectural after Nord and Hogstrom, 2017) and regimental. We argue that our case study points to the opening up of spaces of *potentiality* within the current penal estate in the form of small units that present opportunities for different entanglements to emerge.

We begin by exploring the re-institutionalisation of mental health care within the penal estate and its manifestations within England and Wales, before introducing existing research on control-care in institutional contexts. We then situate these debates in analysis of the creation and operation of a new unit for prisoners with SMIs in the North of England. Our analysis elucidates the emergent, contingent and complex spatialities of care within the prison, as the Unit develops into an institution within an institution.

The (re)institutionalisation of mental health care within the penal estate

The deinstitutionalisation of mental health care began in many countries in the global north in the decades following the second world war (Dear and Wolch, 1987; Joseph et al, 2009). It was based upon the emergence of psychosocial approaches as well as the introduction of new, psychotropic drugs (Dear and Wolch, 1987). However, by the 1980s, it was already apparent that there was a re-spatialisation of mentally unwell populations into in inner city areas (Dear and Wolch, 1987) and the criminal justice system (Urmer, 1975; Lamb and Grant, 1982). Nickerson (1985:1)

argued that prisons had become a ‘poor man’s mental hospital’ (cited in Dear and Wolch, 1987: 174).

> The lack of adequate community supports has also led to incarceration of the mentally disabled within the criminal justice system for crimes more indicative of their mental health disabilities than criminal intent[…] prisons and jails are now being deluged with mentally disabled persons (Dear and Wolch, 1987: 174).

It has been argued that in New Zealand this de-insitutionalisation also intersected with the neoliberal logics of restructuring (Joseph and Kearns, 1996). Recently, the decision to build nine new-build prisons in the UK has also been ‘driven by logics of cost, efficiency and security’(Moran, Jewkes and Turner, 2016: 119; Jewkes and Moran, 2015). Meeting the mental healthcare needs of prisoners has been subordinated to efficiency and security. Or, more importantly, whilst some attention is paid to creating spaces that generally promote mental health and well-being (Houston et al, 1988; Schaeffer et al, 1988), the specific healthcare needs of those with serious mental illnesses (SMIs) are not addressed.

Brooker & Ullmann (2008) argue that prison has become a ‘catch-all’ social and mental healthcare service, and a breeding ground for poor mental health. Thus, revealing a two-fold process through which those with mental healthcare needs are more likely to find themselves – like other socially marginalised groups – within the prison estate, however that spaces of incarceration also contribute to poor mental health. In one study (Bebbington et al, 2017), researchers found that in the year before imprisonment, 25.3% of respondents had used mental health services. The Prison Reform Trust (2018) also found that over 16% of men said they had received treatment for a mental health problem in the year before custody, and 15% of men in prison reported symptoms indicative of psychosis (compared with 4% in the general public).

There has been a ‘profound paradigm or model shift in the care of persons with severe mental illness’, where psychiatric inpatient care in the USA is now provided in

jails and prisons (Lamb & Weinberger, 2005). In research in Cook County jail in Chicago (Ford, 2015), a third of those incarcerated suffer psychological disorders. As Peck (2003: 225) has argued we are seeing 'a more punitive approach to social marginality'. In mental healthcare, this shift marks not so much a de-institutionalisation as a re-institutionalisation within prisons; raising questions concerning how prisons as institutions are situated in relation to control and care (Philo and Parr, 2019).

Mental health care in prisons in England and Wales

In England and Wales, the prevalence of mental health problems in the prison population is much higher than that found in the general population (Brooker and Gojkovic, 2009). However, the range and scale of the issues experienced make treatment complex. Bebbington et al (2017) found that of their sample of prisoners, 12% met criteria for psychosis; 53.8% for depressive disorders; 26.8% for anxiety disorders; 33.1% were dependent on alcohol and 57.1% on illegal drugs; 34.2% had some form of personality disorder; and 69.1% had two disorders or more. The House of Commons Committee of Public Accounts (2017) identified record numbers of suicides and incidents of self-harm in English prisons. In 2016-17, the prison population stood at 84,674; there were 120 self-inflicted deaths and 40,161 incidents of self-harm in prisons in England and Wales (see also Towl and Crichton, 2017).

Mentally ill prisoners 'trouble' (Disney and Schliehe, 2019) the organisation and delivery of appropriate health care within the prison setting, and more widely in the health economy (Walsh and Freshwater, 2009). The complexity of prisoner mental health problems is compounded by the intersection of mental illness with other problems such as substance misuse and/or personality problems, as well as family and social difficulties (Crichton and Nathan, 2015). Since 1992, prison governors have been responsible for 'purchasing healthcare'; provision is via a mixture of public, third and private sector contractors, contributing to a 'challenging environment in which to manage and deliver healthcare' (Powell et al, 2010: 1263). There is a tension in 'delivering care in a punitive environment' (Gojkovic, 2010:

284). Although prison governors are expected to work under demands for equivalence of healthcare for prisoners with the general population, as Niveau (2007: 610) has argued, 'from a clinical view, the principle of equivalence is often insufficient to take account of the adaptations necessary for the organization of care in a correctional setting'.

Treatment within the prison setting in England and Wales has generally focused on the use of in-reach teams, similar to those found in community settings. The care given by these teams unsettles control-care within the wider prison setting and contributes to the unevenness of carceral space (Moran et al, 2018). Prisoners entering prison are assessed for their healthcare needs and any prisoner requiring mental health support should be referred on to in-reach mental health teams. However, healthcare staff undertaking initial assessments are often operating outside of their sphere of expertise in relation to mental health (Wright et al, 2014). Early intervention is hindered and prison in-reach teams are often overwhelmed by the number of referrals. Concerns have been raised about the unrealistic expectations prison staff have in relation to provision by in-reach teams (Wright et al, 2014). Internal structures and the mixture of healthcare providers as well as prison staff hinder the provision of care and treatment to prisoners with mental health needs. In-reach teams are also often simply too small to meet the health needs of all prisoners (Jordan, 2011).

In particular, prisons have become increasingly unable to deal with demand for care for those with serious mental illness (Dyer et al, forthcoming). For prisoners requiring transfer to a psychiatric hospital, there is a shortage of both high and medium security beds within the National Health Service(NHS) – 'the NHS secure beds system is blocked', with only 24 transfers from a prison to a high security bed in 2013, and a correspondingly high waiting list for 'medium secure' beds (Sloan and Allison 2014). Yeung (2016) reported an increase of 20% in male prisoners being transferred to hospital under the 1983 Mental Health Act in English and Welsh prisons, suggesting some movement in the system but also indicative of the level of need. This has meant that prisons increasingly depend upon spatial strategies of

separation and isolation, e.g. in high-security Segregation Units (Segs), to deal with the high numbers of prisoners with SMIs awaiting transfer (Dyer et al, forthcoming).

> No matter how high the quality of healthcare offered to prisoners, if the regime and conditions within prisons cannot be influenced then any benefits from health services will be rapidly lost when the patient, when well, again becomes a prisoner. (Squires, 1996: 1161).

Therefore, given that in-reach teams cannot meet the demands placed upon them and that prison environments and regimes are also impacting upon mental health and well-being, Jordan (2011) has argued that mental ill health in prisons is not solely a concern for the NHS trusts and other providers of health care but for Her Majesty's Prison and Probation Service (HMPPS) as a whole.[1] There is a need for health care for people with SMIs in prisons, which is not being met by current provision but for which there is also no space within the penal estate. This is the dilemma facing many prison governors and healthcare providers across England and Wales; a question not so much of careful control (Turner and Moran, 2019), but of differentiated regimes of control-care for certain groups.

Tightness and constraint in the penal estate

Growing problems with mental health in prisons are occurring at the same time as accelerating increases in prison numbers and overcrowding. Between 1995 and 2010 the prison population increased by 66%, an average of about 4.5% per annum (Allen and Watson, 2017). As of December 2016, 69% of prisons were classified as overcrowded (Allen and Watson, 2017). A key reason for this is the high rate of recidivism – nearly half of adult releases have been re-convicted within a year (Ministry of Justice, 2017). The prison estate itself tends to exacerbate some of the problems within prisons (Crewe, 2011). Many prison buildings were constructed

[1] There is a Government target that prisoners should wait no longer than 14 days for transfer to a secure hospital (as described in the Department of Health, 2011) Good Practice Procedure Guide for transferring and remitting remand, unsentenced and sentenced adult (18 years and over) prisoners to and from inpatient treatment under the Mental Health Act). As of November 2017, 24% of secure hospital transfers that had taken place since 2016 had taken longer than 14 days (House of Commons Library, 2018; Parliamentary Questions, 2017).

more than a century ago and are unfit for a prison regime that is focused on rehabilitation.

Over the time during which the current prison estate has evolved, there has been a shift in overall emphasis of the role of incarceration from punishment and surveillance to more subtle controls and 'learning'. 'Invisible pedagogy' now shapes much of our carceral space (Henley, 2003: 13), and prison environments have become less repressive mentally and emotionally (Jewkes and Johnston, 2012). However, the 'pains of imprisonment' may have shifted to be less direct, but discipline and regulation are simply more efficient rather than less damaging (Crewe, 2011 after Foucault). There has been a softening of penal power, locating it in paperwork relating to privileges and other elements of prison regimes (Crew, 2011: 511). Health care professionals play a role in this coercive potential through the assessments they carry out. As Franko Aas (2014) has argued, in structured clinical interviewing, prisoners are often forced to fit their stories into the 'information system', which is too rigid to capture the complexity and ambiguity of their lives and their experiences. The labels emerging from such a system are de-humanizing and endure within a prisoner's file.

Within the development of the new prison estate, there is recognition that prisons are also mental health facilities and should be able to perform the functions of a mental health unit. Prison design needs to assist staff in their day to day activities and make them feel valued and agents of change. Key elements of design include cells which allow for autonomy (sense of control) (Mehay et al, 2019), communal areas which prisoners contribute to maintaining and systems of rewards that give access to particular spaces as incentives (Crewe, 2007, 2009).

Whilst prisoners may appear to have greater autonomy within the current penal estate than earlier regimes, they are consequently held responsible for their actions and expected to self-govern. Appropriate behaviour is very narrowly defined and the resultant constraints are best understood as a 'tightness'; a shell of penality that is carried with the prisoners (Crewe, 2011). Treatment from prisoners with SMIs must

take place within this tightness and they may be too unwell to self-govern, resulting in inappropriate behaviour that disturbs the balance of the penal environment. Therefore, mental health needs shape spatialities of prison life even when not being accommodated. The example we explore in this paper points to a potentially significant shift in previous approaches to this entanglement of mental illness and criminality, which first Foucault (1965) and later Philo (2004) argue has historically led to an institutional separation of the treatment of mental ill health from the confinement of 'criminals'.

Critical analysis of prison architecture has played a role in debates to address issues of mental ill health within the UK's prisons. Interest in environmental psychology in the late 1980s highlighted the importance of social climate (Houston et al, 1988) and the role of the prison environment in creating this, but Wortley has argued, there has been a clear narrative that focuses upon 'creating safe situations rather than creating safe individuals' (2002: 4). Such questions are at the heart of the tensions between control and care within institutions.

Enfolding spatialities of control and care

Questions of control and care (Disney and Schliehe, 2019) and their enfolding spatialities (McGeachan, 2019) are the focus of ongoing work in institutional geographies (Philo and Parr, 2019; Philo and Parr, 2000). Schliehe (2017) in her research in prisons and secure units in Scotland found that care beyond baseline need, i.e. food, hygiene, exercise, was often subordinated to control. Schliehe has also argued that whilst '[t]he secure psychiatric unit […] is much more lenient than secure care or prison […] all used privileges and their withdrawal as a measure of control' (2016: 29). Consequently, '[t]he process of social control that is exercised in a total institution is very detailed and closely restrictive […], a lot more so than in the surrounding society' (Schliehe, 2016: 29). Prisons are, therefore, settings for diverse processes and practices of control and care. There is a need to understand healthcare settings as more than places of medical treatment and intervention, but as spaces of wider material practices of giving and receiving care (Parr et al, 2003). When exploring both personal and institutional care we should pay attention to

purpose, power and particularity (Tronto, 2010); recognising that care is relational (Koggel, 1998; Nedelsky, 2008).

> Analysing the spatial production of mental health service use involves a move away from seeing mental health in cognitive or biological terms, towards placing location at the forefront of analysis (which is often an afterthought in mental health care) Tucker (2010: 527).

Forensic units are a form of carcero-therapeutic space, i.e. they confine for the purposes of safety and security, as well as seeking to therapise both within and through space. Tucker et al (2019: 29) claim that such units are 'one of the few remaining institutional spaces of mental health care.' However, this is not the case if we consider prisons (after Lamb and Weinberg, 2005) as now the most important institutionalised spaces for mental health care. Mehay et al (2019: 55) argue that the 'health status of prisoners […] relies on how people respond, adapt and adjust to mitigate those risks [i.e. of prison itself] to health'. Their work focuses on the ways in which prisoners make adaptations to their cells, the food they consume, etc. to mitigate the impacts of incarceration on their physical and mental well-being. They argue that that this negotiation of care and containment is still relevant in the prison context and that individuals are able to 'renegotiate and reclaim control'. However, their study refers to general health and well-being rather than those with serious illnesses, who may not be able to make such adaptations on their own.

If we are to understand care as situated and entangled in place (de la Bellacasa, 2017), then prisons as particular settings for and of care have specific entanglements. Care cannot be disentangled from the messiness of its *situ*. De la Bellacasa argues for a need to understand three dimensions of care: maintenance, i.e. the practicalities of helping others to survive; affection, i.e. concern for the wellbeing of others; and ethics/politics, i.e. ideological motivations to improve care of others.

The question we pose here relates to how adaptation unfolds when there are specific care needs within the penal estate that only apply to certain groups of prisoners. McGeachan (2019) explores the enveloping nature of care and control; but she also suggests that whilst care can exert control, control can often succeed in igniting care. The Unit that forms the focus of the rest of this paper emerged as a result of this process, i.e. the control of prisoners with SMIs was proving troublesome within the mainstream penal estate, thus sparking the creation of a new unit to provide care for these inmates within the prison setting as care outside of the prison was delayed.

Making space for mental health care in the North of England's penal estate

In the rest of the paper, we draw upon data from research undertaken in a new unit (hereafter referred to as the Unit) for the treatment of prisoners with SMIs[2] within a reception prison in the North of England[3]. The creation of the Unit was driven by the growing number of prisoners within the region awaiting transfer to a secure mental health facility for treatment (Dyer et al, forthcoming). It was also underpinned by a logic of economic efficiencies due to the costs of keeping such prisoners either in the segregation unit or hospital wing for long periods of time. The managers of the local NHS trust contracted with in-reach mental health provision and the prison governors hoped that treatment within the Unit would reduce referrals to secure facilities by enabling more prisoners to be returned to mainstream prison locations.

> It is proposed that this service will provide a dedicated place within the prison to care and treat men presenting with serious mental illness. This service will not prevent delays in appropriate transfer to mental health beds and the model supports short term transfer to [NHS Trust] low secure beds [ward name] for a maximum of 16 weeks. The service will be supported by two dedicated prison officers[…] This was the preferred option of Offender Health […] Services, in light of optimal service delivery, quality and generic feedback from service users. (Dyer et al, forthcoming).

[2] For the rest of the paper, the prisoners with SMIs admitted to the Unit will be referred to as 'the patients' and 'the prisoners' will be used for the two prisoner-cleaners, who were located on the Unit.
[3] The name of the prison and its exact location have not been revealed in order to conceal the identity of some of the staff referenced later in the paper.

The residential Unit provides a service for male remand and sentenced prisoners (adult and young offenders) with SMIs across the region (excluding Category A offenders based upon level of security).[4] It began to accept referrals in October 2017.[5] It operates within a small wing within the region's reception prison where there are 12 cells, 11 for residents, one to a cell, and one cell for two prisoners specifically selected to work on the unit as cleaners or as PID (prisoner information desk) workers. The Unit was planned as a transitional space that would enable swift (within a month or two) transfer on to a secure unit for those still in need or a return to main location within the prison for those whose condition improved.

The Unit is set over two floors. The entrance to the Unit is centrally located. After entering, to the immediate left there are four cells that stretch to the end of the Unit along the same wall. At the end, located in the middle of the room there is a staircase up to the second floor and a pool table is located at the bottom of the stairs in front of the cells.

[4] The Unit was attached to one of the main wings within the prison, which had opened in the 1810s with 600 cells. The Unit itself had been built in the 1980s and was much smaller than the surrounding wings. It was located very close to the gatehouse and the yard where prison vans would enter to drop off prisoners. The attached wing was home to many of the vulnerable prisoners on site, which staff commented provided a reputational risk for those transferred to the Unit, and was one of the reasons some prisoners refused to be referred there.

[5] Prisoners had to have the capacity to agree to referral to the Unit and, therefore, it was not suitable for some of those who were the most unwell. This was, in particular, a barrier to referrals from other prisons in the region, as many prisoners did not want to be transferred. The admissions criteria themselves also evolved over time. Descriptions in policy documents varied from prisoners with 'serious mental illness' to 'acute and/or severe and complex mental health needs' (Dyer et al, forthcoming). One team member later stated that referrals could be made for those with 'an identified mental health problem – serious mental Illness, learning disability, autism, and personality disorder' but also prisoners who are 'emotionally unstable with no serious mental illness noted by the referrer'(ibid). All referrals were reviewed by the clinical leads and psychiatrist on a Monday morning to determine who would be admitted/discharged in the coming week.

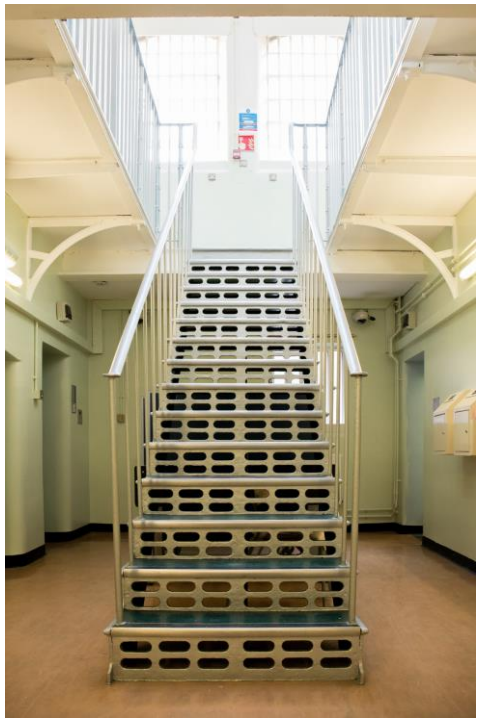

Figure 1: The staircase from the ground floor

On the opposite wall there is the clinical lead's office, as well as another locked administrative room and behind the stairs there is storage area without a door. Directly opposite the entrance the Unit has an open communal space with an exit to the outdoor yard and greenhouse (see figure 3 below). To the right and immediately overlooking the communal area is the Unit's main administrative office, where the prison guards and healthcare staff have access to computers. Behind the main office there is also a small kitchen used by the staff, which is only accessible through the office. To the immediate right of the entrance is the cleaners' room, where there are sinks and some equipment is stored. Next along this right-hand wall is a dispensary, after which the corridor narrows and at the far end on the right is an art therapy/group room. On the second floor, at the top of the stairs, cells line the two walls along the landings with the stair opening in the middle.

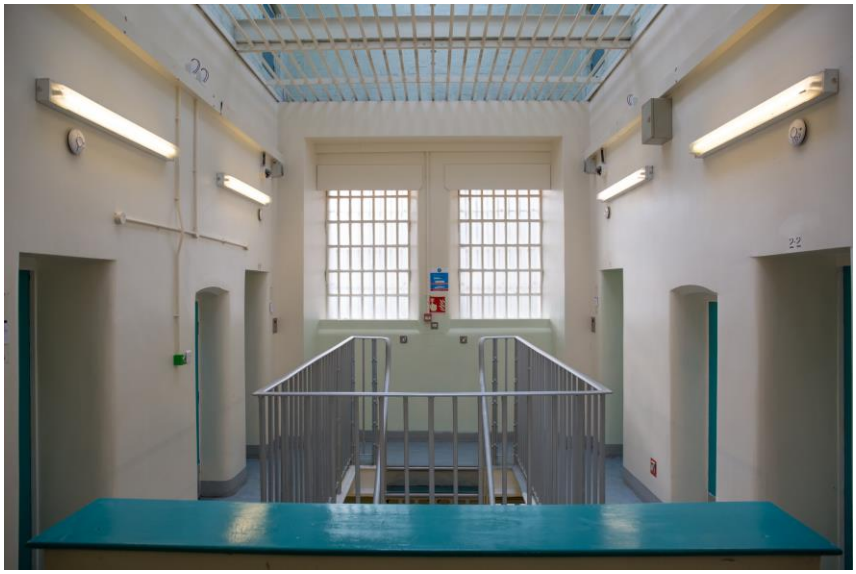

Figure 2: The landing areas and cells on the first (upper) floor

Further along some cells are set back from a smaller communal area, including one with a photochromatic door. At the far end are the showers and the cell shared by the two prison cleaners. Through a locked door at the far end of the second floor is a large meeting room[6], staff kitchen and offices used by the mental health in-reach team. This locked area provides access to a staircase to other floors and administrative rooms in the main wing.

The research team undertook non-participant observation on the Unit from October 2017 to October 2018, participant observation at monthly Steering Group meetings from November 2016 to November 2018, and analysis of relevant background documents, including minutes of meetings between stakeholders.[7] In addition, a minimum dataset (MDS), recording information pertaining to referrals, activities and outcomes, was created by the research team and populated by healthcare staff working in the unit. Semi-structured interviews with 16 key stakeholders between

[6] This meeting room was used by the previous occupants of the wing – a drug and alcohol recovery team/service – for group sessions and activities for the prisoners. However, it was never used by the Unit for patient/prisoner activities and was eventually taken over by the mental health team.

[7] We use participant and non-participant observation here to denote the differing roles within these observations. Whilst on the steering committee, members of the research team actively participated in and contributed to discussions shaping the development of the Unit, during visits to the Unit observations were primarily undertaken at some distance with little interaction with the patients. General clarifying questions were asked of staff, but time was mostly spent with staff in discussions, rather than participating in the everyday life of the Unit itself.

January and May 2018 were also undertaken.

Making space for care

Accounts of carceral space that include the need for therapeutic elements often focus on particular initiatives that will improve mental health and wellbeing through changes to the design or additions that are shaped by an intentionality. For example, 'nature contact' is used within carceral spaces to reduce stress and increase calm (Moran, 2019). The enfolding spatialities of control-care on the Unit were transformed by both *intentional* therapeutic interventions but they also evolved through an openness and *potentiality*, supported by the Unit's experimental underpinnings and ad-hoc development. The spatialities of the Unit entwined control and care (both-and) in the planned designation of different spaces as well as in the making of the space through the actions and practices of the multiple actors working and living in the Unit.

> We had to think about best model – something that would adapt as it goes along. The service had to fit. There were two potential models – but then we were offered one wing in *[prison name]* because it is a remand prison […] if there was unlimited funds I would build a new wing […] A designated hospital within the prison is the way it is going […] the advantage is the process of moving people with acute need would be smoother and it would be dedicated for prison transfer (Interview, NHS manager, 16 April, 2018)

The manager describes the initiative as having to *fit* into the prison estate but also having the *potential* to adapt, i.e. that this was part of an ongoing process of carving out space for this type of care within the prison system. There is, however, an objective, 'a designated hospital within the prison'. In this way s/he envisages that the prison would not need to be connected to wider healthcare services.

Small adaptations began to emerge fairly soon after the Unit opened. The lead nurse described the process by which the patients had come to start eating in the communal area downstairs. One patient was using food to block pipes in his cell, so

the healthcare staff needed to bring him into a space where his eating could be surveilled. They placed a small old table in the area outside the administrative office where the patient would sit on his own to eat. One day, another patient sat down with him. As more patients joined them, so the space became an informal dining hall and the original small table now sits to one side.

Figure 3: The downstairs communal area on the Unit

The space continued to develop over the months and became a key element of the caring environment of the unit. This sat in sharp contrast with some of the planned therapeutic spaces, the development of which stalled over a number of months. These included a de-escalation room, which remained a store for cleaning and leisure materials, as suitable soft furnishings did not arrive. There were delays in the fitting of the photochromatic door to a cell on the first floor, which prevented the *purposing* of other spaces. In the downstairs group/art therapy room, a failure in heating made the room unusable for a period of time. NHS managers frequently referenced the fact that they were doing anything to support the patients as being better than the previous situation; highlighting a tension in terms of constraints on the purposiveness of the Unit (de la Bellacasa, 2017) within the wider political and fiscal context.

However, the healthcare staff found their own ways to continue with their therapeutic changes. A healthcare assistant worked with one of the cleaners to

develop the group/art therapy room. The cleaner noted that this room had been used as an art room when the unit had previously been used for treating addiction and substance misuse; there was overlapping and continuity with earlier uses of the space. There were some concerns about support for the development of creative space on the wing, which illustrated that conflict over the *purposing* of space were also perceived to be embedded in the power relations and hierarchies in the Unit. Such conflict over space also reflects wider tensions between control and care as certain approaches to caring were subordinated to others (Schliehe, 2017). In particular, the physical needs of caring for the body, i.e. cleanliness, hygiene, exercise, as well as compliance in taking medication, are often prioritised ahead of some therapeutic interventions, such as group therapy or art therapy. They reflect the specific issues of carceral spaces where bodies are confined together for long periods of time in small spaces. However, in patients with mental health needs their ability to care for themselves physically is inhibited by their mental health condition.

Treatments, such as drug therapy, which were more closely related to clinical plans for wellbeing and would facilitate a more rapid return to the mainstream prison environment, were prioritised over psychosocial approaches. This was part of the conscious 'working out' (Tronto, 2010) of aspects of care within the Unit. Here, the *purposiveness* of the Unit as an institution was not comparable to that of a hospital (Tronto, 2010). It did not seek long-term recovery for the residents, rather to improve health to a level sufficient for return to mainstream prison. Staff recognised that this approach could lead to future re-admissions given the negative impact of the wider prison on prisoners with SMIs, as well as the continued dependence on compliance with medication plans (Squires, 1996).

Emergent spatial autonomy

In addition to the emergent *purposing* of space for caring within the Unit, the healthcare staff also appeared to be supporting a drive for some level of autonomy to minimise daily connections between the Unit and the rest of the prison. Research on autonomy within prisons frequently focuses on individual autonomy and highlights the agency of prisoners in adapting to carceral space (Mehay et al, 2019;

van den Laan and Eichelsheim, 2013) as well as prison officers (Kommer, 1993), which polarises prisoner and officer/institutional processes and practices of making space. However, multiple spaces within prisons are also shaped through third parties, who challenge this binary relationality. Moran (2013) highlights the liminality of prison visiting rooms and the role of the visitors in creating this inside-outside space. Healthcare staff and other workers in prisons also offer links to the outside; their operations are not liminal but central to prisons. Their activities stretch into the very heart of the penal estate.

This connection to the outside is embedded in the prison approach to health care, which is based upon the premise of 'equivalence' (Shaw and Elgar, 2015) mentioned earlier. Health care is one of the key areas in which prison life is not expected to deviate from that beyond prison walls. This wider politics and ethics of caring, therefore, shaped the spatialities of the prison and formed the framework for the relative autonomy with which the Unit was permitted to operate. This autonomy was also not spatially peripheral, like the visiting rooms, but centrally located within the prison itself, with the Unit being nestled in between much larger wings. Unlike the new healthcare centre, which was set apart from the main buildings, up a hill, the Unit was adapted from a former wing for the treatment of substance misuse and, therefore, built on a legacy of another differentially situated space.

This autonomy was unique to the Unit and not shared by other spaces of mental health care in the prison. The work of the in-reach mental health team stretched out into the main spaces of the prison, dominated by prison regimes, which made caring difficult at times. The mental health in-reach team had little opportunity to impact on the main functioning of the wings. The in-reach team were instead expected to consult and treat within existing institutional spaces and regimes. The manager of the in-reach mental health team explained that 40- 50% of those coming into the prison are referred to the team and as it is the reception prison they often don't stay very long and are unsettled. The team, therefore, are required to make very quick assessments of prisoners based upon very little contact. Unlike in the Unit, the prisoners in the main prison are locked up for 23 hours a day. She explained that as

an older prison there are very few spaces for therapeutic assessment or interventions on the main wings. Some of the team's assessments take place through just a few minutes of conversation at the door of the prisoner's cell. Therefore, whilst the in-reach team can gain some sense of what treatment might be needed, their overall focus is on risk assessment and management of conditions.

There were a number of ways in which healthcare staff sought to dis/connect the Unit from the normal functioning of the rest of the prison. Firstly, the regime on the Unit was open-door throughout the day with the prisoners only being locked in their cells for an hour after lunch. This marked a reversal of the situation in the rest of the prison where the men were locked in their cells for 23 hours most days. Men on the Unit experienced space differently. Yet we should not equate this freedom to move around as less control, but as Moran and Turner (2018) have suggested perhaps a more careful rendering of control. The Unit might be viewed as being differentially positioned on Repo's 'complex continuum of care and control' (2019: 234), where the controlling practices are those which are more prevalent in care settings than penal contexts. For example, although the atmosphere appeared relaxed, the men on the wing as patients were subject to much more intensive observation of their actions and words than they would have been within the mainstream prison or even the segregation unit. This shift of control from prison guards to healthcare staff also meant a change in the relationships between prisoners and prison officers (Bottomley et al, 1994).

> You know, these have come, generally, from the wing. So, you might deal with them, but unfortunately on the wings, you don't have the time to deal with them. Whereas, on here, obviously you spend all day with them. They're out the cells all day. Whereas on the wing you tend to be… More… I don't know what the word is. Probably more disciplined with them. (Focus Group, Prison Officer 22 February 2018)

The officer highlights how the different spatial regime – in this case the open doors – shifts behaviour towards the patients and prisoners. Being in space together undisciplines the relationships that are prevalent within the rest of the prison. The

primary functioning of the prison and prison guards – discipline and control – (Mehay et al, 2019) breaks down in this sharing of space. However, this breakdown is also due a loosening of control on patients' and prisoners' behaviour by other prisoners, as another prison officer explained.

> The likelihood is they wouldn't come and sit with us, and engage with us, the way that the lads do on here. Because they don't want to be really seen to be engaging with us, do they? In the main jail? They'd rather talk to the pad mate, or just not talk to anybody at all. Where the lads here – I feel as if they're quite open, and they are wanting to come and engage with us and sit and play dominoes and things like that. On the main jail, that would not happen. (Focus Group, Prison Officer, 22 February 2018).

The discipline that permeated relationships and created boundaries with prison staff in the rest of the prison was also, therefore, unravelled by the different activities taking place on the unit. Due to the open-door regime, activities in communal spaces were much more important on the Unit than in the rest of the prison. However, given the small number of patients, prisoners and staff, as well as how acutely unwell some of the patients were for periods of time, prison staff often needed to engage in activities with patients and prisoners to make them possible. Consequently, we frequently found prison officers playing pool with prisoners when we visited the Unit. This differentiated regime was disrupted at times by the relocation of officers to other parts of the prison when there were staff shortages. This remained a frustration for healthcare staff throughout the period of research, as it impacted upon their regime of control-care and they began to log occasions when this happened in order to raise it with the prison authorities.

After opening, the Unit had greater spatial connections to the rest of the prison as there were some delays in making the Unit's showers suitable for use by prisoners with SMIs, e.g. through removing potential ligature points. During this time, the patients and prisoners had to visit the neighbouring wing. Healthcare staff were concerned at the impact that this had on levels of personal care and hygiene

amongst patients on the Unit. Once the showers were made available, healthcare staff sought to address other issues that meant the patients needed to visit other areas of the prison, and thus impacted on the spatial autonomy of the Unit.

Appointments to see the general practitioner were only possible on the neighbouring wing. The lead nurse planned to adapt the existing treatment room, which was serving as a dispensary for the patients' medications, so that the doctor could visit the Unit itself for two appointments per week. The lead nurse argued that they would not need a full treatment room on the Unit, as this would be far too expensive, but instead they would use a screen and a chair so some healthcare checks/appointments could be undertaken. The suggestion did not appear to be based upon feedback from the patients on the Unit itself, but upon healthcare staff's views (Mol, 2008), which constrained the mobilities of the patients and dis/connected them further from the rest of the prison.

The spatial autonomy that the healthcare staff sought for the unit was driven not only by its different regime but the controlled care, which they had sought to develop. The lack of funding had led to an ad-hoc development of the space, as described above. Rather than the planned resourcing of the unit, which would have connected it through institutional materialities, e.g. matching chairs, etc., the Unit appeared mis-matched. This suggested a different institutional 'dwelling in' space. On the Unit, it was the healthcare staff not prisoners (Mehay et al, 2019) who supported material changes that marked the Unit out from the wider prison context. Their investments in these smaller adaptations sat alongside some of the incomplete elements of the formal renovations and the underused areas that pointed to institutional barriers to the development of the Unit. This autonomy did not go un-noticed and nor was it without concern. Healthcare and prison staff sometimes reflected on the fact that some patients would need to return to 'normal location', i.e. the main wings of this or another prison. They were concerned that such returns would be hampered by the increasing disparities between everyday life on the Unit and the wider prison. This disquiet was subordinated to meeting what they felt were the patients more immediate care needs.

Dwelling in a small space

In this final section, we explore the role of 'small spaces' within the prison and compare the development of the Unit to research undertaken on the environment of similar small developments within the penal estate.

> In E&W *[England & Wales]*, prisons have arguably been designed and built to contain offenders as cheaply and securely as possible, in living standards that meet minimum legislative requirements but whose potential to re-socialise and resettle inmates post-release is questionable (Moran, Turner and Jewkes, 2016: 4).

Wider economic pressure to drive down costs has meant that there is a general trend towards concentrating prisoners in larger prisoners. However, the prison estate lags behind this trend and within this wider process there are different still smaller units emerging, particularly with experimental regimes, which might differ from the wider prison. Small units and their 'difficult prisoners' have often been absent from accounts of penal system history (Nellis, 2010; Turner and Peters, 2015; McGeachan, 2019). Therefore, research on their environments has only recently begun to emerge.

One of the issues identified by staff at Barlinnie Special Unit[8] was the difficulties some prisoners had in coping with the freedom, lack of structure and close staff-prisoner relationships (McGeachan, 2019). This was mainly problematic for those who had spent extended periods of time in other parts of the prison or in other institutions. The change in regime made some prisoners feel particularly vulnerable (Bottomley et al, 1994). Prisoners and staff found it difficult to shed roles that had become ingrained in other parts of the prison system (Carmichael, 1982 cited in McGeachan, 2019). The spaces of the unit enabled small acts of caring that help to bridge this divide. Unlike at Barlinnie, in the context of the Unit, the presence of

[8] An experimental unit for the most 'difficult' prisoners that operated within HMP Barlinnie in Scotland from 1973 to 1994.

caring staff, i.e. the healthcare workers, also helped to support the prison staff in disrupting this divide.

The Unit had a re-humanizing effect as staff were able to spend periods of times in a small space with just a few inmates. In the ground floor communal area, we encountered staff playing pool with patients and prisoners. In Norway, staff and prisoners in small prisons experience relationships with each other more positively (Johnsen et al, 2011). However, it is not just the size of the space, but also the use of it, for example, in the Netherlands prisoners in double cells viewed their interactions with staff less positively (Beijersbergen et al, 2016). On the Unit, only the two cleaners were forced to share a cell, meaning that patients could potentially withdraw into their cell at any time for respite (Hemsworth, 2016), depending on whether they were subject to particular levels of surveillance of control relating to their condition. However, these findings are not universal, with some studies pointing to greater misconduct in smaller prisons (perhaps due to enhanced reporting) (McGeachan, 2019).

The focus group with the prison officers highlighted the importance of the size of the Unit for staff-prisoner, staff-patient relationships.

> I think when you work on here[…]you know you're still working in the jail, but you become a bit detached from the jail. […] And I think because you've got so many on a large wing, you're unable to assess the individual properly. So, you would deal with them, I think, a little bit different as to what you would on here. Because we get to know them better, really, on here. And their little traits (Focus Group, Prison Officer, 22 February 2018).

Smallness is referred to here as not only of the unit but also the small traits that might be difficult to detect in a larger place. These small traits rehumanize the inmates. A key element in improving mental health and well-being in small units is the reduction in noise.

> I still think that some individuals would need to come to this environment to feel a little bit more secure, get themselves in the right place, and address lots of other issues that they've got. As well as having the medication, and then feeling comfortable to go back out on the wing. Because it's daunting, to go on a wing with 200 prisoners. If you're a quiet person and you have mental health issues. (Focus Group, Prison Officer, 22 February 2018).

The smallness of the environment in this case is perceived to be of benefit to prisoners in need of treatment for mental health issues. This is linked to the differential soundscape of the Unit. 'In prisons, soundworlds can be as inclusive as they are exclusive, as convivial as they are hostile, and as therapeutic as they are torturous' (Hemsworth, 2016: 91). Prisons are noisy, cacophonous even, and this can be intimidating, especially to newcomers (Stewart, 1997). Prisoners often seek quiet in their own cells or through admission to segregation or isolation units in order to gain relief from the noise of prison, however this quiet can rapidly become oppressive (Hemsworth, 2016). Auditory capacities differ between individuals and this means that the impact of prison soundscapes can be differentially experienced.

The small scale of the Unit did impact upon the capacity to provide appropriate care for all the patients. Healthcare staff observed that patients would simply attend whatever groups were running even if they were not suitable for treating their own illness or were not therapeutic at all; most of the patients on the Unit attended the bible studies group and those without auditory hallucinations attended the 'hearing voices' group. There were concerns that this might impact upon the efficacy of group interventions, which are often premised on the basis of shared experience. The small size of the Unit limited the number of healthcare staff and meant that the range of treatments could not match those of a larger facility. At times patients were not always able to access the most relevant treatments for them beyond their immediate clinical and medication needs, raising once more the question of control-care, i.e. of providing care that extends beyond control over the most immediate symptoms of serious mental illness.

Conclusions

> [T]here is merit in staying with the trouble of the institution, with troubling institutions, because there is so much more to learn, to know and to apply if we wish to stop institutions from being such troubling spaces seemingly unable to respond open-handedly to the troubled and even the troublesome (Philo and Parr, 2019: 246)

In this paper we have illustrated the merits of staying with one type of troubling institution – the prison - and a particular institutional trouble – mental illness. In doing so, we have brought together work from the fields of geographies of mental health and carceral geographies to consider their intersections within institutional forms. Our example illustrates how one prison has sought to care for some of its most troubled and, consequently, troublesome residents – prisoners with serious mental illnesses. Our research illustrates that as space has been made for the differential control-care of these prisoners, there has been an openness to *potentiality*. Developments have been experimental, emergent and incomplete; not officially challenging wider institutional processes but eluding them. They have created an institution within an institution with a certain level of spatial autonomy. Such autonomy has appeared desirable to healthcare staff, who sense that the 'shell' of incarceration carried by prisoners within the rest of the institution (Crewe, 2011) is too tight for vulnerable patients. Yet unlike in the past and perhaps due to the immediate constraints posed by austerity politics (particularly in terms of bed availability within NHS secure units) and the pressures emanating out of the privatisation of parts of the penal estate, the Unit marks an attempt to treat these prisoners *within* carceral institutions. In making this space the relationships between the prison officers and prisoners on the Unit have been transformed; freed by the scale and the regime of the Unit, their differential encounters in space have facilitated new understandings. On a more practical note, the autonomy of the Unit has also liberated the patients from the 'troubling' aspects of the wider institution, i.e. those elements which negatively impact their mental health, such as noise

(Hemsworth, 2016), overcrowding (Crewe, 2011; Allen and Watson, 2017) and enclosure (Mehay et al, 2019).

Yet, healthcare staff remain 'troubled' by the temporariness of such relief (Hemsworth, 2016); by the potential that the work they have undertaken with the patients will unravel rapidly on a return to 'normal location' (Squires, 1996). Making space for the Unit has created an institution within an institution that has had little impact upon the processes and practices of control-care within the prison itself. The Unit, enfolded within the wider prison, offers patients hope, but this is constrained. These limits loom large in the minds of the staff, just like the surrounding wings loom large over the Unit itself.

Emergent ideas to develop the experimental approach have focused on two different spatial strategies: firstly, a growth in the Unit itself, i.e. making more space for this form of control-care within the prison itself; secondly, the transfer of the model to other prisons, i.e. making more space within the penal estate. Both spatial strategies demonstrate a commitment to transformation from within the institution and a turning away from externalising solutions for mental health care. The first strategy appears problematic from our analysis, in that certain aspects of the *smallness* of the space emerge as part of its success; particularly in the creation of a different soundscape that appears beneficial to some of the patients. The second strategy presents us with the question of whether the *happenstance* character of the development of the Unit, which was *undisciplined* enough to open up new possibilities within the prison, can, in fact, be replicated if transferred elsewhere. Will the lessons learned from the Unit lead to a more systematic and programmed development of other units that preclude similar avenues for *potentiality*? Therefore, the recommendation may be not simply to copy the model the Unit presents wholesale elsewhere, but to replicate the *process*, which has been characterised by experimentation and a lack of discipline that some penal institutions may find troubling in and of itself. This latter point seems to suggest that in addressing the trouble of serious mental illness, prisons as institutions may have to intentionally become more 'troubled' through experimentation within.

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